Appendix Figure 1. Survey on Workforce Planning Modifications

Workforce Planning Survey

Which of the following strategies did you utilize to expand workforce?

	Yes, still utilizing	Yes, but discontinued	Planned, but didn't implement	No
Added/redeployed non-hospitalists	○	○	○	○
Added/redeployed APPs	○	○	○	○
Added/redeployed fellows	○	○	○	○
Hospitalists supervising other clinicians	○	○	○	○
Hospitalists caring for critically ill patients	○	○	○	○
Reduction in non-essential services (surgical co-management, pre-operative assessments)	○	○	○	○
Redeployment of residents	○	○	○	○
Locums	○	○	○	○

Which of the following strategies did you utilize to expand admitting capacity?

	Yes, still utilizing	Yes, but discontinued	Planned, but didn't implement	No
Increase patient care units / beds covered?	○	○	○	○
Transfer patients to other facilities	○	○	○	○
Geographic cohorting	○	○	○	○
Community surge areas	○	○	○	○

Which of the following strategies did you utilize to maintain workforce wellness and patient safety?

	Yes, still utilizing	Yes, but discontinued	Planned, but didn't implement	No
Decrease team census	○	○	○	○
Health care worker surveillance	○	○	○	○
Change in rotation frequency	○	○	○	○
Restructure or expand teams	○	○	○	○
Virtual visits	○	○	○	○
Decrease documentation requirements	○	○	○	○
Exempt providers at high-risk from care of COVID-19 patients	○	○	○	○

How frequently have you reassessed your staffing strategy?

○ Daily
○ Weekly
○ Monthly

Who was involved in decision-making regarding staffing and deployment (Hospital Medicine group, Department, health system)?

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Appendix Table 1.

Adaptation	Description of Adaptation/Example
Staffing reassessment	Assessed how frequently leadership reassessed staffing strategy (daily, weekly)
Geographic cohorting of COVID-19 patients	Selecting a particular area or unit of the hospital for COVID-19 patients, as opposed to distributing the patients throughout the hospital, or mixing COVID-19 patients with non-COVID-19 patients
Care team restructuring	Changing the number of patients or providers per team, adjusting the members of the care team (for example, changing the team census or adding an APP to a team)
Expanded bed capacity	Overflow of internal medicine or COVID-19 patients into areas or units of the hospital that would typically be set aside for other services or purposes. For instance, if beds typically reserved for surgical teams were used for internal medicine teams, utilizing operating room space or recovery room space, etc.
Non-essential service reduction	Reduction of planned elective surgeries, non-urgent or non-emergent clinic visits, etc.
Use of inpatient virtual visits	Utilizing electronic communication with admitted patients to avoid additional exposure during the day. In the original survey this was simply called “virtual visits” but due to the discussion on the HOMERuN calls, this was understood to mean virtual visits in the inpatient setting.
Transfer of patients to other facilities	Transferring patients from one hospital to another to balance census or reserve resources, or to an alternative care site.
Use of community surge areas	Transfer of patients (with or without COVID-19) to new sites in the community that were created due to the surge in cases or strain on the healthcare system. For instance, in New York City the Javits Center and the USS Comfort were “community surge areas”
Redeploying clinicians	Asking clinicians (APP, fellow, resident, attending) to work on services that they do not typically cover. For instance, redeploying cardiology fellows to general medicine or COVID-19 teams.
Redeploying hospitalists to intensive care settings	Asking hospitalists to work in the intensive care unit, when this was not a part of their typical scope of practice or role at the institution.
Hospitalist supervision of other clinicians	Asking hospitalists to supervise clinicians deployed to general medicine or COVID-19 teams.
Hiring locum tenens physicians	Hiring locum tenens physicians who were not previously employed to expand clinician workforce
Surveying clinicians for illness	Any method of assessing clinicians for potential symptoms of covid-19, including daily symptom reporting
Exempting high risk clinicians from COVID-19 care	This was defined differently by different institutions, but was meant to assess if there was a clear process in place for exempting clinicians thought to be at high risk if exposed to COVID-19, rather than asking clinicians to advocate for themselves.